

AMENDED IN ASSEMBLY AUGUST 1, 2016

AMENDED IN SENATE APRIL 20, 2016

AMENDED IN SENATE APRIL 5, 2016

SENATE BILL

No. 1335

Introduced by Senator Mitchell

February 19, 2016

An act to amend Section 14132.100 of, and to add ~~Sections~~ *Section* 14124.28 and 14687 to, the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

SB 1335, as amended, Mitchell. ~~Med-Cal~~ *Medi-Cal* benefits: federally qualified health centers and rural health centers: Drug Medi-Cal and specialty mental health services.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income persons receive health care benefits, including specialty mental health services. The Medi-Cal program is, in part, governed and funded by federal Medicaid provisions. *Under existing law, specialty mental health services are generally provided by mental health plans that contract with the department.*

Existing law establishes the Drug Medi-Cal Treatment Program (Drug Medi-Cal), under which the department is authorized to enter into contracts with each county for various alcohol and drug treatment services, including substance use disorder services, narcotic treatment program services, naltrexone services, and outpatient drug-free services, to Medi-Cal beneficiaries. ~~Specialty mental health services and Drug Medi-Cal Services and provided pursuant to waivers from the federal~~

~~Centers for Medicare and Medicaid Services, beneficiaries, or the department is required to directly arrange for these services if a county elects not to do so.~~

Existing law provides that federally qualified health center (FQHC) services and rural health clinic (RHC) services, as defined, are covered benefits under the Medi-Cal program to be reimbursed, to the extent that federal financial participation is obtained, to providers on a per-visit basis. Existing law authorizes FQHCs and RHCs to elect to have pharmacy or dental services reimbursed on a fee-for-service basis, utilizing the current fee schedules established for those services and requires those costs to be adjusted out of the FQHC's or RHC's clinic base rate as scope-of-service changes.

This bill additionally would authorize FQHCs and RHCs to elect to provide *services under* Drug Medi-Cal and to receive reimbursement for those services pursuant to the terms of a contract or contracts mutually agreed upon by the FQHC or RHC and the county or the department, pursuant to specified requirements. ~~The bill also would authorize FQHCs and RHCs to elect to provide specialty mental health services and to receive reimbursement for those services pursuant to the terms of a contract or contracts mutually agreed upon by the FQHC or RHC and mental health plans that contract with the state. The bill would authorize the counties and the mental health plans would authorize a county to contract with the FQHCs and RHCs for these Drug Medi-Cal services. The bill would authorize an FQHC or RHC that entered into a contract on or before January 1, 2017, with a mental health plan to provide specialty mental health services to continue to provide, and be reimbursed for, those specialty mental health services if the costs of providing specialty mental health services are reimbursed outside of the per-visit rate.~~

The bill's requirements would be implemented only to the extent that federal financial participation is available and any federal approvals have been obtained.

This bill would incorporate additional changes in Section 14132.100 of the Welfare and Institutions Code proposed by AB 1863, that would become operative only if AB 1863 and this bill are both chaptered and become effective on or before January 1, 2017, and this bill is chaptered last.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 14132.100 of the Welfare and Institutions Code is amended to read:

14132.100. (a) The federally qualified health center services described in Section 1396d(a)(2)(C) of Title 42 of the United States Code are covered benefits.

(b) The rural health clinic services described in Section 1396d(a)(2)(B) of Title 42 of the United States Code are covered benefits.

(c) Federally qualified health center services and rural health clinic services shall be reimbursed on a per-visit basis in accordance with the definition of “visit” set forth in subdivision (g).

(d) Effective October 1, 2004, and on each October 1 thereafter, until no longer required by federal law, federally qualified health center (FQHC) and rural health clinic (RHC) per-visit rates shall be increased by the Medicare Economic Index applicable to primary care services in the manner provided for in Section 1396a(bb)(3)(A) of Title 42 of the United States Code. Prior to January 1, 2004, FQHC and RHC per-visit rates shall be adjusted by the Medicare Economic Index in accordance with the methodology set forth in the state plan in effect on October 1, 2001.

(e) (1) An FQHC or RHC may apply for an adjustment to its per-visit rate based on a change in the scope of services provided by the FQHC or RHC. Rate changes based on a change in the scope of services provided by an FQHC or RHC shall be evaluated in accordance with Medicare reasonable cost principles, as set forth in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations, or its successor.

(2) Subject to the conditions set forth in subparagraphs (A) to (D), inclusive, of paragraph (3), a change in scope of service means any of the following:

(A) The addition of a new FQHC or RHC service that is not incorporated in the baseline prospective payment system (PPS) rate, or a deletion of an FQHC or RHC service that is incorporated in the baseline PPS rate.

(B) A change in service due to amended regulatory requirements or rules.

1 (C) A change in service resulting from relocating or remodeling
2 an FQHC or RHC.

3 (D) A change in types of services due to a change in applicable
4 technology and medical practice utilized by the center or clinic.

5 (E) An increase in service intensity attributable to changes in
6 the types of patients served, including, but not limited to,
7 populations with HIV or AIDS, or other chronic diseases, or
8 homeless, elderly, migrant, or other special populations.

9 (F) Any changes in any of the services described in subdivision
10 (a) or (b), or in the provider mix of an FQHC or RHC or one of
11 its sites.

12 (G) Changes in operating costs attributable to capital
13 expenditures associated with a modification of the scope of any
14 of the services described in subdivision (a) or (b), including new
15 or expanded service facilities, regulatory compliance, or changes
16 in technology or medical practices at the center or clinic.

17 (H) Indirect medical education adjustments and a direct graduate
18 medical education payment that reflects the costs of providing
19 teaching services to interns and residents.

20 (I) Any changes in the scope of a project approved by the federal
21 Health Resources and Services Administration (HRSA).

22 (3) No change in costs shall, in and of itself, be considered a
23 scope-of-service change unless all of the following apply:

24 (A) The increase or decrease in cost is attributable to an increase
25 or decrease in the scope of services defined in subdivisions (a) and
26 (b), as applicable.

27 (B) The cost is allowable under Medicare reasonable cost
28 principles set forth in Part 413 (commencing with Section 413) of
29 Subchapter B of Chapter 4 of Title 42 of the Code of Federal
30 Regulations, or its successor.

31 (C) The change in the scope of services is a change in the type,
32 intensity, duration, or amount of services, or any combination
33 thereof.

34 (D) The net change in the FQHC's or RHC's rate equals or
35 exceeds 1.75 percent for the affected FQHC or RHC site. For
36 FQHCs and RHCs that filed consolidated cost reports for multiple
37 sites to establish the initial prospective payment reimbursement
38 rate, the 1.75-percent threshold shall be applied to the average
39 per-visit rate of all sites for the purposes of calculating the cost
40 associated with a scope-of-service change. "Net change" means

1 the per-visit rate change attributable to the cumulative effect of all
2 increases and decreases for a particular fiscal year.

3 (4) An FQHC or RHC may submit requests for scope-of-service
4 changes once per fiscal year, only within 90 days following the
5 beginning of the FQHC's or RHC's fiscal year. Any approved
6 increase or decrease in the provider's rate shall be retroactive to
7 the beginning of the FQHC's or RHC's fiscal year in which the
8 request is submitted.

9 (5) An FQHC or RHC shall submit a scope-of-service rate
10 change request within 90 days of the beginning of any FQHC or
11 RHC fiscal year occurring after the effective date of this section,
12 if, during the FQHC's or RHC's prior fiscal year, the FQHC or
13 RHC experienced a decrease in the scope of services provided that
14 the FQHC or RHC either knew or should have known would have
15 resulted in a significantly lower per-visit rate. If an FQHC or RHC
16 discontinues providing onsite pharmacy or dental services, it shall
17 submit a scope-of-service rate change request within 90 days of
18 the beginning of the following fiscal year. The rate change shall
19 be effective as provided for in paragraph (4). As used in this
20 paragraph, "significantly lower" means an average per-visit rate
21 decrease in excess of 2.5 percent.

22 (6) Notwithstanding paragraph (4), if the approved
23 scope-of-service change or changes were initially implemented
24 on or after the first day of an FQHC's or RHC's fiscal year ending
25 in calendar year 2001, but before the adoption and issuance of
26 written instructions for applying for a scope-of-service change,
27 the adjusted reimbursement rate for that scope-of-service change
28 shall be made retroactive to the date the scope-of-service change
29 was initially implemented. Scope-of-service changes under this
30 paragraph shall be required to be submitted within the later of 150
31 days after the adoption and issuance of the written instructions by
32 the department, or 150 days after the end of the FQHC's or RHC's
33 fiscal year ending in 2003.

34 (7) All references in this subdivision to "fiscal year" shall be
35 construed to be references to the fiscal year of the individual FQHC
36 or RHC, as the case may be.

37 (f) (1) An FQHC or RHC may request a supplemental payment
38 if extraordinary circumstances beyond the control of the FQHC
39 or RHC occur after December 31, 2001, and PPS payments are
40 insufficient due to these extraordinary circumstances. Supplemental

1 payments arising from extraordinary circumstances under this
2 subdivision shall be solely and exclusively within the discretion
3 of the department and shall not be subject to subdivision (l). These
4 supplemental payments shall be determined separately from the
5 scope-of-service adjustments described in subdivision (e).
6 Extraordinary circumstances include, but are not limited to, acts
7 of nature, changes in applicable requirements in the Health and
8 Safety Code, changes in applicable licensure requirements, and
9 changes in applicable rules or regulations. Mere inflation of costs
10 alone, absent extraordinary circumstances, shall not be grounds
11 for supplemental payment. If an FQHC's or RHC's PPS rate is
12 sufficient to cover its overall costs, including those associated with
13 the extraordinary circumstances, then a supplemental payment is
14 not warranted.

15 (2) The department shall accept requests for supplemental
16 payment at any time throughout the prospective payment rate year.

17 (3) Requests for supplemental payments shall be submitted in
18 writing to the department and shall set forth the reasons for the
19 request. Each request shall be accompanied by sufficient
20 documentation to enable the department to act upon the request.
21 Documentation shall include the data necessary to demonstrate
22 that the circumstances for which supplemental payment is requested
23 meet the requirements set forth in this section. Documentation
24 shall include all of the following:

25 (A) A presentation of data to demonstrate reasons for the
26 FQHC's or RHC's request for a supplemental payment.

27 (B) Documentation showing the cost implications. The cost
28 impact shall be material and significant, two hundred thousand
29 dollars (\$200,000) or 1 percent of a facility's total costs, whichever
30 is less.

31 (4) A request shall be submitted for each affected year.

32 (5) Amounts granted for supplemental payment requests shall
33 be paid as lump-sum amounts for those years and not as revised
34 PPS rates, and shall be repaid by the FQHC or RHC to the extent
35 that it is not expended for the specified purposes.

36 (6) The department shall notify the provider of the department's
37 discretionary decision in writing.

38 (g) (1) An FQHC or RHC "visit" means a face-to-face
39 encounter between an FQHC or RHC patient and a physician,
40 physician assistant, nurse practitioner, certified nurse-midwife,

1 clinical psychologist, licensed clinical social worker, or a visiting
2 nurse. For purposes of this section, “physician” shall be interpreted
3 in a manner consistent with the Centers for Medicare and Medicaid
4 Services’ Medicare Rural Health Clinic and Federally Qualified
5 Health Center Manual (Publication 27), or its successor, only to
6 the extent that it defines the professionals whose services are
7 reimbursable on a per-visit basis and not as to the types of services
8 that these professionals may render during these visits and shall
9 include a physician and surgeon, podiatrist, dentist, optometrist,
10 and chiropractor. A visit shall also include a face-to-face encounter
11 between an FQHC or RHC patient and a comprehensive perinatal
12 services practitioner, as defined in Section 51179.1 of Title 22 of
13 the California Code of Regulations, providing comprehensive
14 perinatal services, a four-hour day of attendance at an adult day
15 health care center, and any other provider identified in the state
16 plan’s definition of an FQHC or RHC visit.

17 (2) (A) A visit shall also include a face-to-face encounter
18 between an FQHC or RHC patient and a dental hygienist or a
19 dental hygienist in alternative practice.

20 (B) Notwithstanding subdivision (e), an FQHC or RHC that
21 currently includes the cost of the services of a dental hygienist in
22 alternative practice for the purposes of establishing its FQHC or
23 RHC rate shall apply for an adjustment to its per-visit rate, and,
24 after the rate adjustment has been approved by the department,
25 shall bill these services as a separate visit. However, multiple
26 encounters with dental professionals that take place on the same
27 day shall constitute a single visit. The department shall develop
28 the appropriate forms to determine which FQHC’s or ~~RHC~~ RHC’s
29 rates shall be adjusted and to facilitate the calculation of the
30 adjusted rates. An FQHC’s or RHC’s application for, or the
31 department’s approval of, a rate adjustment pursuant to this
32 subparagraph shall not constitute a change in scope of service
33 within the meaning of subdivision (e). An FQHC or RHC that
34 applies for an adjustment to its rate pursuant to this subparagraph
35 may continue to bill for all other FQHC or RHC visits at its existing
36 per-visit rate, subject to reconciliation, until the rate adjustment
37 for visits between an FQHC or RHC patient and a dental hygienist
38 or a dental hygienist in alternative practice has been approved.
39 Any approved increase or decrease in the provider’s rate shall be
40 made within six months after the date of receipt of the department’s

1 rate adjustment forms pursuant to this subparagraph and shall be
2 retroactive to the beginning of the fiscal year in which the FQHC
3 or RHC submits the request, but in no case shall the effective date
4 be earlier than January 1, 2008.

5 (C) An FQHC or RHC that does not provide dental hygienist
6 or dental hygienist in alternative practice services, and later elects
7 to add these services, shall process the addition of these services
8 as a change in scope of service pursuant to subdivision (e).

9 (h) If FQHC or RHC services are partially reimbursed by a
10 third-party payer, such as a managed care entity (as defined in
11 Section 1396u-2(a)(1)(B) of Title 42 of the United States Code),
12 the Medicare Program, or the Child Health and Disability
13 Prevention (CHDP)—~~program~~, *Program*, the department shall
14 reimburse an FQHC or RHC for the difference between its per-visit
15 PPS rate and receipts from other plans or programs on a
16 contract-by-contract basis and not in the aggregate, and may not
17 include managed care financial incentive payments that are required
18 by federal law to be excluded from the calculation.

19 (i) (1) An entity that first qualifies as an FQHC or RHC in the
20 year 2001 or later, a newly licensed facility at a new location added
21 to an existing FQHC or RHC, and any entity that is an existing
22 FQHC or RHC that is relocated to a new site shall each have its
23 reimbursement rate established in accordance with one of the
24 following methods, as selected by the FQHC or RHC:

25 (A) The rate may be calculated on a per-visit basis in an amount
26 that is equal to the average of the per-visit rates of three comparable
27 FQHCs or RHCs located in the same or adjacent area with a similar
28 caseload.

29 (B) In the absence of three comparable FQHCs or RHCs with
30 a similar caseload, the rate may be calculated on a per-visit basis
31 in an amount that is equal to the average of the per-visit rates of
32 three comparable FQHCs or RHCs located in the same or an
33 adjacent service area, or in a reasonably similar geographic area
34 with respect to relevant social, health care, and economic
35 characteristics.

36 (C) At a new entity's one-time election, the department shall
37 establish a reimbursement rate, calculated on a per-visit basis, that
38 is equal to 100 percent of the projected allowable costs to the
39 FQHC or RHC of furnishing FQHC or RHC services during the
40 first 12 months of operation as an FQHC or RHC. After the first

1 12-month period, the projected per-visit rate shall be increased by
2 the Medicare Economic Index then in effect. The projected
3 allowable costs for the first 12 months shall be cost settled and the
4 prospective payment reimbursement rate shall be adjusted based
5 on actual and allowable cost per visit.

6 (D) The department may adopt any further and additional
7 methods of setting reimbursement rates for newly qualified FQHCs
8 or RHCs as are consistent with Section 1396a(bb)(4) of Title 42
9 of the United States Code.

10 (2) In order for an FQHC or RHC to establish the comparability
11 of its caseload for purposes of subparagraph (A) or (B) of paragraph
12 (1), the department shall require that the FQHC or RHC submit
13 its most recent annual utilization report as submitted to the Office
14 of Statewide Health Planning and Development, unless the FQHC
15 or RHC was not required to file an annual utilization report. FQHCs
16 or RHCs that have experienced changes in their services or
17 caseload subsequent to the filing of the annual utilization report
18 may submit to the department a completed report in the format
19 applicable to the prior calendar year. FQHCs or RHCs that have
20 not previously submitted an annual utilization report shall submit
21 to the department a completed report in the format applicable to
22 the prior calendar year. The FQHC or RHC shall not be required
23 to submit the annual utilization report for the comparable FQHCs
24 or RHCs to the department, but shall be required to identify the
25 comparable FQHCs or RHCs.

26 (3) The rate for any newly qualified entity set forth under this
27 subdivision shall be effective retroactively to the later of the date
28 that the entity was first qualified by the applicable federal agency
29 as an FQHC or RHC, the date a new facility at a new location was
30 added to an existing FQHC or RHC, or the date on which an
31 existing FQHC or RHC was relocated to a new site. The FQHC
32 or RHC shall be permitted to continue billing for Medi-Cal covered
33 benefits on a fee-for-service basis until it is informed of its
34 enrollment as an FQHC or RHC, and the department shall reconcile
35 the difference between the fee-for-service payments and the
36 FQHC's or RHC's prospective payment rate at that time.

37 (j) Visits occurring at an intermittent clinic site, as defined in
38 subdivision (h) of Section 1206 of the Health and Safety Code, of
39 an existing FQHC or RHC, or in a mobile unit as defined by
40 paragraph (2) of subdivision (b) of Section 1765.105 of the Health

1 and Safety Code, shall be billed by and reimbursed at the same
2 rate as the FQHC or RHC establishing the intermittent clinic site
3 or the mobile unit, subject to the right of the FQHC or RHC to
4 request a scope-of-service adjustment to the rate.

5 (k) (1) Notwithstanding any other provision of this section
6 requiring the use of a per-visit reimbursement rate, as described
7 in subdivision ~~(a)~~; (c), this subdivision shall govern reimbursement
8 for services identified in this subdivision.

9 (2) An FQHC or RHC may elect to have pharmacy services or
10 dental services reimbursed on a fee-for-services basis, utilizing
11 the current fee schedules established for those services.

12 ~~(3) If an FQHC or RHC and one or more mental health plans~~
13 ~~that contract with the department pursuant to Section 14712~~
14 ~~mutually agree to enter into a contract to have the FQHC or RHC~~
15 ~~provide specialty mental health services to Medi-Cal beneficiaries~~
16 ~~as part of the mental health plan's network, the FQHC or RHC~~
17 ~~shall elect to have specialty mental health services reimbursed~~
18 ~~pursuant to the terms of the contract or contracts and outside of~~
19 ~~the per-visit PPS rate.~~

20 ~~(4)~~

21 (3) An FQHC or RHC may elect to become certified to provide
22 services in the Drug Medi-Cal program, and reimbursement for
23 those services shall be governed by this paragraph.

24 (A) If the FQHC is located in a county that has elected to
25 participate in the Drug Medi-Cal organized delivery system, the
26 FQHC or RHC may elect to receive reimbursement pursuant to a
27 mutually agreed upon contract between the county and the FQHC
28 or RHC.

29 (B) If the county does not elect to participate in the Drug
30 Medi-Cal organized delivery system, an FQHC or RHC may elect
31 to contract through the department as a Drug Medi-Cal provider.

32 ~~(5)~~

33 (4) (A) If an FQHC or RHC elects reimbursement pursuant to
34 paragraph ~~(2), (3), or (4)~~, (2) or (3), pursuant to which the costs
35 associated with providing the services are part of the FQHC's or
36 RHC's clinic base rate, those costs shall be adjusted out of the
37 FQHC's or RHC's clinic base rate as scope-of-service changes
38 and payment pursuant to subdivision (h) shall not apply.

39 (B) An FQHC or RHC that reverses its election under ~~this~~
40 ~~subdivision paragraph (2) or (3)~~ shall revert to its prior rate,

1 subject to an increase to account for all MEI increases occurring
2 during the intervening time period, and subject to any increases
3 or decreases associated with applicable—scope-of-services
4 *scope-of-service* adjustments as provided in subdivision (e).

5 (5) (A) *If an FQHC or RHC entered into a contract on or before*
6 *January 1, 2017, with a mental health plan to provide specialty*
7 *mental health services to Medi-Cal beneficiaries as part of the*
8 *mental health plan’s network, the FQHC or RHC may continue*
9 *to provide, and be reimbursed for, those specialty mental health*
10 *services pursuant to the terms of the contract with the mental health*
11 *plan if the costs of providing specialty mental health services are*
12 *reimbursed outside of the per-visit PPS rate described in*
13 *subdivision (c).*

14 (B) *For purposes of this paragraph, “mental health plan” means*
15 *any mental health plan contracting with the department to provide*
16 *specialty mental health services to enrolled Medi-Cal beneficiaries*
17 *under Article 5 (commencing with Section 14680) of Chapter 8.8*
18 *or Chapter 8.9 (commencing with Section 14700).*

19 (l) FQHCs and RHCs may appeal a grievance or complaint
20 concerning ratesetting, scope-of-service changes, and settlement
21 of cost report audits, in the manner prescribed by Section 14171.
22 The rights and remedies provided under this subdivision are
23 cumulative to the rights and remedies available under all other
24 provisions of law of this state.

25 (m) The department shall, no later than March 30, 2008,
26 promptly seek all necessary federal approvals in order to implement
27 this section, including any amendments to the state plan. To the
28 extent that any element or requirement of this section is not
29 approved, the department shall submit a request to the federal
30 Centers for Medicare and Medicaid Services for any waivers that
31 would be necessary to implement this section.

32 (n) The department shall implement this section only to the
33 extent that federal financial participation is obtained.

34 SEC. 1.5. *Section 14132.100 of the Welfare and Institutions*
35 *Code is amended to read:*

36 14132.100. (a) The federally qualified health center services
37 described in Section 1396d(a)(2)(C) of Title 42 of the United States
38 Code are covered benefits.

(b) The rural health clinic services described in Section 1396d(a)(2)(B) of Title 42 of the United States Code are covered benefits.

(c) Federally qualified health center services and rural health clinic services shall be reimbursed on a per-visit basis in accordance with the definition of “visit” set forth in subdivision (g).

(d) Effective October 1, 2004, and on each October 1 thereafter, until no longer required by federal law, federally qualified health center (FQHC) and rural health clinic (RHC) per-visit rates shall be increased by the Medicare Economic Index applicable to primary care services in the manner provided for in Section 1396a(bb)(3)(A) of Title 42 of the United States Code. Prior to January 1, 2004, FQHC and RHC per-visit rates shall be adjusted by the Medicare Economic Index in accordance with the methodology set forth in the state plan in effect on October 1, 2001.

(e) (1) An FQHC or RHC may apply for an adjustment to its per-visit rate based on a change in the scope of services provided by the FQHC or RHC. Rate changes based on a change in the scope of services provided by an FQHC or RHC shall be evaluated in accordance with Medicare reasonable cost principles, as set forth in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations, or its successor.

(2) Subject to the conditions set forth in subparagraphs (A) to (D), inclusive, of paragraph (3), a change in scope of service means any of the following:

(A) The addition of a new FQHC or RHC service that is not incorporated in the baseline prospective payment system (PPS) rate, or a deletion of an FQHC or RHC service that is incorporated in the baseline PPS rate.

(B) A change in service due to amended regulatory requirements or rules.

(C) A change in service resulting from relocating or remodeling an FQHC or RHC.

(D) A change in types of services due to a change in applicable technology and medical practice utilized by the center or clinic.

(E) An increase in service intensity attributable to changes in the types of patients served, including, but not limited to,

1 populations with HIV or AIDS, or other chronic diseases, or
2 homeless, elderly, migrant, or other special populations.

3 (F) Any changes in any of the services described in subdivision
4 (a) or (b), or in the provider mix of an FQHC or RHC or one of
5 its sites.

6 (G) Changes in operating costs attributable to capital
7 expenditures associated with a modification of the scope of any
8 of the services described in subdivision (a) or (b), including new
9 or expanded service facilities, regulatory compliance, or changes
10 in technology or medical practices at the center or clinic.

11 (H) Indirect medical education adjustments and a direct graduate
12 medical education payment that reflects the costs of providing
13 teaching services to interns and residents.

14 (I) Any changes in the scope of a project approved by the federal
15 Health Resources and ~~Service~~ *Services* Administration (HRSA).

16 (3) No change in costs shall, in and of itself, be considered a
17 scope-of-service change unless all of the following apply:

18 (A) The increase or decrease in cost is attributable to an increase
19 or decrease in the scope of services defined in subdivisions (a) and
20 (b), as applicable.

21 (B) The cost is allowable under Medicare reasonable cost
22 principles set forth in Part 413 (commencing with Section 413) of
23 Subchapter B of Chapter 4 of Title 42 of the Code of Federal
24 Regulations, or its successor.

25 (C) The change in the scope of services is a change in the type,
26 intensity, duration, or amount of services, or any combination
27 thereof.

28 (D) The net change in the FQHC's or RHC's rate equals or
29 exceeds 1.75 percent for the affected FQHC or RHC site. For
30 FQHCs and RHCs that filed consolidated cost reports for multiple
31 sites to establish the initial prospective payment reimbursement
32 rate, the 1.75-percent threshold shall be applied to the average
33 per-visit rate of all sites for the purposes of calculating the cost
34 associated with a scope-of-service change. "Net change" means
35 the per-visit rate change attributable to the cumulative effect of all
36 increases and decreases for a particular fiscal year.

37 (4) An FQHC or RHC may submit requests for scope-of-service
38 changes once per fiscal year, only within 90 days following the
39 beginning of the FQHC's or RHC's fiscal year. Any approved
40 increase or decrease in the provider's rate shall be retroactive to

1 the beginning of the FQHC's or RHC's fiscal year in which the
2 request is submitted.

3 (5) An FQHC or RHC shall submit a scope-of-service rate
4 change request within 90 days of the beginning of any FQHC or
5 RHC fiscal year occurring after the effective date of this section,
6 if, during the FQHC's or RHC's prior fiscal year, the FQHC or
7 RHC experienced a decrease in the scope of services provided that
8 the FQHC or RHC either knew or should have known would have
9 resulted in a significantly lower per-visit rate. If an FQHC or RHC
10 discontinues providing onsite pharmacy or dental services, it shall
11 submit a scope-of-service rate change request within 90 days of
12 the beginning of the following fiscal year. The rate change shall
13 be effective as provided for in paragraph (4). As used in this
14 paragraph, "significantly lower" means an average per-visit rate
15 decrease in excess of 2.5 percent.

16 (6) Notwithstanding paragraph (4), if the approved
17 scope-of-service change or changes were initially implemented
18 on or after the first day of an FQHC's or RHC's fiscal year ending
19 in calendar year 2001, but before the adoption and issuance of
20 written instructions for applying for a scope-of-service change,
21 the adjusted reimbursement rate for that scope-of-service change
22 shall be made retroactive to the date the scope-of-service change
23 was initially implemented. Scope-of-service changes under this
24 paragraph shall be required to be submitted within the later of 150
25 days after the adoption and issuance of the written instructions by
26 the department, or 150 days after the end of the FQHC's or RHC's
27 fiscal year ending in 2003.

28 (7) All references in this subdivision to "fiscal year" shall be
29 construed to be references to the fiscal year of the individual FQHC
30 or RHC, as the case may be.

31 (f) (1) An FQHC or RHC may request a supplemental payment
32 if extraordinary circumstances beyond the control of the FQHC
33 or RHC occur after December 31, 2001, and PPS payments are
34 insufficient due to these extraordinary circumstances. Supplemental
35 payments arising from extraordinary circumstances under this
36 subdivision shall be solely and exclusively within the discretion
37 of the department and shall not be subject to subdivision (l). These
38 supplemental payments shall be determined separately from the
39 scope-of-service adjustments described in subdivision (e).
40 Extraordinary circumstances include, but are not limited to, acts

1 of nature, changes in applicable requirements in the Health and
2 Safety Code, changes in applicable licensure requirements, and
3 changes in applicable rules or regulations. Mere inflation of costs
4 alone, absent extraordinary circumstances, shall not be grounds
5 for supplemental payment. If an FQHC's or RHC's PPS rate is
6 sufficient to cover its overall costs, including those associated with
7 the extraordinary circumstances, then a supplemental payment is
8 not warranted.

9 (2) The department shall accept requests for supplemental
10 payment at any time throughout the prospective payment rate year.

11 (3) Requests for supplemental payments shall be submitted in
12 writing to the department and shall set forth the reasons for the
13 request. Each request shall be accompanied by sufficient
14 documentation to enable the department to act upon the request.
15 Documentation shall include the data necessary to demonstrate
16 that the circumstances for which supplemental payment is requested
17 meet the requirements set forth in this section. Documentation
18 shall include all of the following:

19 (A) A presentation of data to demonstrate reasons for the
20 FQHC's or RHC's request for a supplemental payment.

21 (B) Documentation showing the cost implications. The cost
22 impact shall be material and significant, two hundred thousand
23 dollars (\$200,000) or 1 percent of a facility's total costs, whichever
24 is less.

25 (4) A request shall be submitted for each affected year.

26 (5) Amounts granted for supplemental payment requests shall
27 be paid as lump-sum amounts for those years and not as revised
28 PPS rates, and shall be repaid by the FQHC or RHC to the extent
29 that it is not expended for the specified purposes.

30 (6) The department shall notify the provider of the department's
31 discretionary decision in writing.

32 (g) (1) An FQHC or RHC "visit" means a face-to-face
33 encounter between an FQHC or RHC patient and a physician,
34 physician assistant, nurse practitioner, certified nurse-midwife,
35 clinical psychologist, licensed clinical social worker, or a visiting
36 nurse. For purposes of this section, "physician" shall be interpreted
37 in a manner consistent with the Centers for Medicare and Medicaid
38 Services' Medicare Rural Health Clinic and Federally Qualified
39 Health Center Manual (Publication 27), or its successor, only to
40 the extent that it defines the professionals whose services are

1 reimbursable on a per-visit basis and not as to the types of services
2 that these professionals may render during these visits and shall
3 include a physician and surgeon, *osteopath*, podiatrist, dentist,
4 optometrist, and chiropractor. A visit shall also include a
5 face-to-face encounter between an FQHC or RHC patient and a
6 comprehensive perinatal-services practitioner, as defined in Section
7 ~~51179.1~~ 51179.7 of Title 22 of the California Code of Regulations,
8 providing comprehensive perinatal services, a four-hour day of
9 attendance at an adult day health care center, and any other provider
10 identified in the state plan's definition of an FQHC or RHC visit.

11 (2) (A) A visit shall also include a face-to-face encounter
12 between an FQHC or RHC patient and a dental-hygienist or
13 *hygienist*, a dental hygienist in alternative-practice, *practice, or a*
14 *marriage and family therapist*.

15 (B) Notwithstanding subdivision (e), *if* an FQHC or RHC that
16 currently includes the cost of the services of a dental hygienist in
17 alternative-practice *practice, or a marriage and family therapist*
18 for the purposes of establishing its FQHC or RHC rate *chooses to*
19 *bill these services as a separate visit, the FQHC or RHC* shall
20 apply for an adjustment to its per-visit rate, and, after the rate
21 adjustment has been approved by the department, shall bill these
22 services as a separate visit. However, multiple encounters with
23 dental professionals *or marriage and family therapists* that take
24 place on the same day shall constitute a single visit. The department
25 shall develop the appropriate forms to determine which FQHC's
26 or-RHC *RHC's* rates shall be adjusted and to facilitate the
27 calculation of the adjusted rates. An FQHC's or RHC's application
28 for, or the department's approval of, a rate adjustment pursuant to
29 this subparagraph shall not constitute a change in scope of service
30 within the meaning of subdivision (e). An FQHC or RHC that
31 applies for an adjustment to its rate pursuant to this subparagraph
32 may continue to bill for all other FQHC or RHC visits at its existing
33 per-visit rate, subject to reconciliation, until the rate adjustment
34 for visits between an FQHC or RHC patient and a dental-hygienist
35 *or hygienist*, a dental hygienist in alternative-practice *practice, or*
36 *a marriage and family therapist* has been approved. Any approved
37 increase or decrease in the provider's rate shall be made within
38 six months after the date of receipt of the department's rate
39 adjustment forms pursuant to this subparagraph and shall be
40 retroactive to the beginning of the fiscal year in which the FQHC

or RHC submits the request, but in no case shall the effective date be earlier than January 1, 2008.

(C) An FQHC or RHC that does not provide dental-hygienist or *hygienist*, dental hygienist in alternative-practice *practice*, or marriage and family therapist services, and later elects to add these services, *services and bill these services as a separate visit*, shall process the addition of these services as a change in scope of service pursuant to subdivision (e).

(h) If FQHC or RHC services are partially reimbursed by a third-party payer, such as a managed care entity (as defined in Section 1396u-2(a)(1)(B) of Title 42 of the United States Code), the Medicare Program, or the Child Health and Disability Prevention (CHDP)-~~program~~, *Program*, the department shall reimburse an FQHC or RHC for the difference between its per-visit PPS rate and receipts from other plans or programs on a contract-by-contract basis and not in the aggregate, and may not include managed care financial incentive payments that are required by federal law to be excluded from the calculation.

(i) (1) An entity that first qualifies as an FQHC or RHC in the year 2001 or later, a newly licensed facility at a new location added to an existing FQHC or RHC, and any entity that is an existing FQHC or RHC that is relocated to a new site shall each have its reimbursement rate established in accordance with one of the following methods, as selected by the FQHC or RHC:

(A) The rate may be calculated on a per-visit basis in an amount that is equal to the average of the per-visit rates of three comparable FQHCs or RHCs located in the same or adjacent area with a similar caseload.

(B) In the absence of three comparable FQHCs or RHCs with a similar caseload, the rate may be calculated on a per-visit basis in an amount that is equal to the average of the per-visit rates of three comparable FQHCs or RHCs located in the same or an adjacent service area, or in a reasonably similar geographic area with respect to relevant social, health care, and economic characteristics.

(C) At a new entity's one-time election, the department shall establish a reimbursement rate, calculated on a per-visit basis, that is equal to 100 percent of the projected allowable costs to the FQHC or RHC of furnishing FQHC or RHC services during the first 12 months of operation as an FQHC or RHC. After the first

1 12-month period, the projected per-visit rate shall be increased by
2 the Medicare Economic Index then in effect. The projected
3 allowable costs for the first 12 months shall be cost settled and the
4 prospective payment reimbursement rate shall be adjusted based
5 on actual and allowable cost per visit.

6 (D) The department may adopt any further and additional
7 methods of setting reimbursement rates for newly qualified FQHCs
8 or RHCs as are consistent with Section 1396a(bb)(4) of Title 42
9 of the United States Code.

10 (2) In order for an FQHC or RHC to establish the comparability
11 of its caseload for purposes of subparagraph (A) or (B) of paragraph
12 (1), the department shall require that the FQHC or RHC submit
13 its most recent annual utilization report as submitted to the Office
14 of Statewide Health Planning and Development, unless the FQHC
15 or RHC was not required to file an annual utilization report. FQHCs
16 or RHCs that have experienced changes in their services or
17 caseload subsequent to the filing of the annual utilization report
18 may submit to the department a completed report in the format
19 applicable to the prior calendar year. FQHCs or RHCs that have
20 not previously submitted an annual utilization report shall submit
21 to the department a completed report in the format applicable to
22 the prior calendar year. The FQHC or RHC shall not be required
23 to submit the annual utilization report for the comparable FQHCs
24 or RHCs to the department, but shall be required to identify the
25 comparable FQHCs or RHCs.

26 (3) The rate for any newly qualified entity set forth under this
27 subdivision shall be effective retroactively to the later of the date
28 that the entity was first qualified by the applicable federal agency
29 as an FQHC or RHC, the date a new facility at a new location was
30 added to an existing FQHC or RHC, or the date on which an
31 existing FQHC or RHC was relocated to a new site. The FQHC
32 or RHC shall be permitted to continue billing for Medi-Cal covered
33 benefits on a fee-for-service basis *under its existing provider*
34 *number* until it is informed of its ~~enrollment as an FQHC or RHC,~~
35 *RHC enrollment approval*, and the department shall reconcile the
36 difference between the fee-for-service payments and the FQHC's
37 or RHC's prospective payment rate at that time.

38 (j) Visits occurring at an intermittent clinic site, as defined in
39 subdivision (h) of Section 1206 of the Health and Safety Code, of
40 an existing FQHC or RHC, or in a mobile unit as defined by

paragraph (2) of subdivision (b) of Section 1765.105 of the Health and Safety Code, shall be billed by and reimbursed at the same rate as the FQHC or RHC establishing the intermittent clinic site or the mobile unit, subject to the right of the FQHC or RHC to request a scope-of-service adjustment to the rate.

(k) (1) Notwithstanding any other provision of this section requiring the use of a per-visit reimbursement rate, as described in subdivision (c), this subdivision shall govern reimbursement for services identified in this subdivision.

(2) An FQHC or RHC may elect to have pharmacy services or dental services reimbursed on a fee-for-services basis, utilizing the current fee schedules established for those services.

(3) An FQHC or RHC may elect to become certified to provide services in the Drug Medi-Cal program, and reimbursement for those services shall be governed by this paragraph.

(A) If the FQHC is located in a county that has elected to participate in the Drug Medi-Cal organized delivery system, the FQHC or RHC may elect to receive reimbursement pursuant to a mutually agreed upon contract between the county and the FQHC or RHC.

(B) If the county does not elect to participate in the Drug Medi-Cal organized delivery system, an FQHC or RHC may elect to contract through the department as a Drug Medi-Cal provider.

(4) (A) If an FQHC or RHC elects reimbursement pursuant to paragraph (2) or (3), pursuant to which the costs associated with providing the services are part of the FQHC's or RHC's clinic base rate, those costs shall be adjusted out of the FQHC's or RHC's clinic base rate as scope-of-service changes and payment pursuant to subdivision (h) shall not apply.

~~*(k)*~~

~~*(B) An FQHC or RHC may elect to have pharmacy or dental services reimbursed on a fee-for-service basis, utilizing the current fee schedules established for those services. These costs shall be adjusted out of the FQHC's or RHC's clinic base rate as scope-of-service changes. An FQHC or RHC that reverses its election under this subdivision paragraph (2) or (3) shall revert to its prior rate, subject to an increase to account for all-MEI Medicare Economic Index increases occurring during the intervening time period, and subject to any-increase increases or*~~

1 ~~decrease decreases~~ associated with applicable ~~scope-of-services~~
2 ~~scope-of-service~~ adjustments as provided in subdivision (e).

3 (5) (A) *If an FQHC or RHC entered into a contract on or before*
4 *January 1, 2017, with a mental health plan to provide specialty*
5 *mental health services to Medi-Cal beneficiaries as part of the*
6 *mental health plan's network, the FQHC or RHC may continue*
7 *to provide, and be reimbursed for, those specialty mental health*
8 *services pursuant to the terms of the contract with the mental health*
9 *plan if the costs of providing specialty mental health services are*
10 *reimbursed outside of the per-visit PPS rate described in*
11 *subdivision (c).*

12 (B) *For purposes of this paragraph, "mental health plan" means*
13 *any mental health plan contracting with the department to provide*
14 *specialty mental health services to enrolled Medi-Cal beneficiaries*
15 *under Article 5 (commencing with Section 14680) of Chapter 8.8*
16 *or Chapter 8.9 (commencing with Section 14700).*

17 (l) FQHCs and RHCs may appeal a grievance or complaint
18 concerning ratesetting, scope-of-service changes, and settlement
19 of cost report audits, in the manner prescribed by Section 14171.
20 The rights and remedies provided under this subdivision are
21 cumulative to the rights and remedies available under all other
22 provisions of law of this state.

23 (m) The department shall, ~~by~~ no later than March 30, 2008,
24 promptly seek all necessary federal approvals in order to implement
25 this section, including any amendments to the state plan. To the
26 extent that any element or requirement of this section is not
27 approved, the department shall submit a request to the federal
28 Centers for Medicare and Medicaid Services for any waivers that
29 would be necessary to implement this section.

30 (n) The department shall implement this section only to the
31 extent that federal financial participation is obtained.

32 SEC. 2. Section 14124.28 is added to the Welfare and
33 Institutions Code, immediately following Section 14124.26, to
34 read:

35 14124.28. Notwithstanding any other provision of this article
36 or regulation adopted thereunder, a county may contract with a
37 federally qualified health center (FQHC) or rural health center
38 (RHC), in accordance with subdivision (k) of Section 14132.100,
39 for the provision of alcohol and drug use services within the county
40 service area.

1 ~~SEC. 3.~~ Section 14687 is added to the Welfare and Institutions
2 Code, to read:

3 ~~14687. Notwithstanding any other provision of this article or~~
4 ~~regulation adopted thereunder, a mental health plan may contract~~
5 ~~with a federally qualified health center (FQHC) or rural health~~
6 ~~center (RHC), in accordance with subdivision (k) of Section~~
7 ~~14132.100, for the provision of specialty mental health services.~~

8 ~~SEC. 4.~~

9 ~~SEC. 3.~~ The amendments made by this act to subdivision (k)
10 of Section 14132.100 of, and the changes made by this act by the
11 addition of ~~Sections~~ Section 14124.28 and 14687 to, the Welfare
12 and Institutions Code shall be implemented only to the extent that
13 federal financial participation is available and any necessary federal
14 approvals have been obtained.

15 ~~SEC. 4.~~ *Section 1.5 of this bill incorporates amendments to*
16 ~~Section 14132.100 of the Welfare and Institutions Code proposed~~
17 ~~by both this bill and Assembly Bill 1863. It shall only become~~
18 ~~operative if (1) both bills are enacted and become effective on or~~
19 ~~before January 1, 2017, (2) each bill amends Section 14132.100~~
20 ~~of the Welfare and Institutions Code, and (3) this bill is enacted~~
21 ~~after Assembly Bill 1863, in which case Section 1 of this bill shall~~
22 ~~not become operative.~~